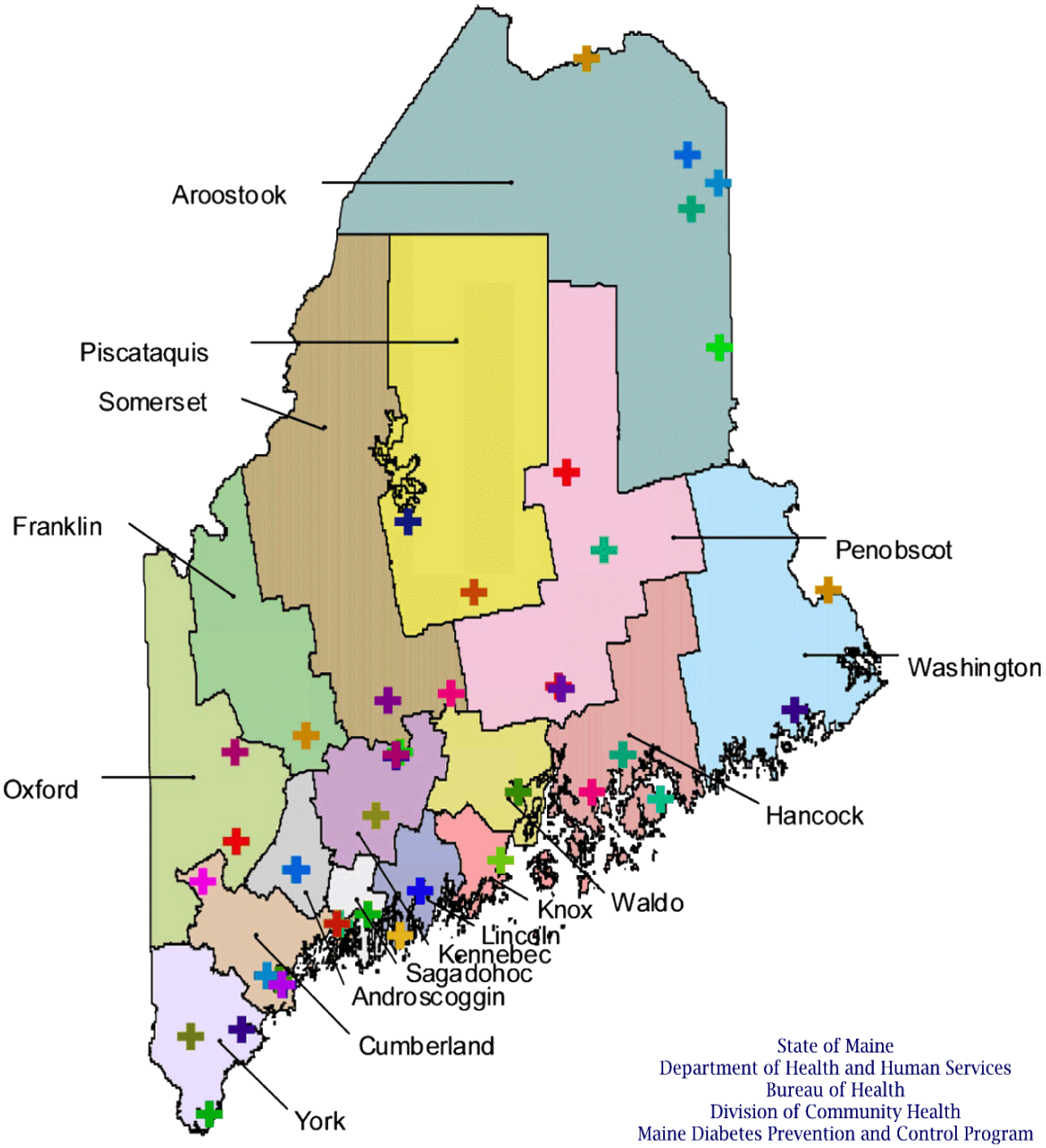
Maine Diabetes Prevention and Control Program (DPCP)

2005 Performance Improvement Plan



State of Maine
Department of Health and Human Services
Bureau of Health
Division of Community Health
Maine Diabetes Prevention and Control Program

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The Maine 2005 Diabetes Surveillance System

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Maine Diabetes Prevention and Control Program

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State Diabetes Health System Assessment

In the fall of 2003 the Maine Center for Public Health (MCPH) conducted a rigorous systems-based assessment of the Statewide Diabetes Health System (SDHS) based on a modified version of the National Public Health Performance Standards (NPHPS) assessment tool which is based on the Essential Public Health Services (EPHS). See Appendix A (EPHS and Indicators). The purpose of this assessment was to identify strengths, limitations, gaps, and needs within the SDHS. The intent was to utilize the results of the assessment as the impetus for the development of an improvement plan.

Assessment Process

The formal assessment was led by an independent third party (MCPH), familiar with, and trained to administer, the state performance measurement tool. The assessment was conducted in the fall of 2003 with a broad range of partners including representatives from the state public health agency. At the time of the assessment, there was no formal definition of the statewide diabetes health system. Therefore, this assessment employed a macro-approach and included all diabetes-related efforts in Maine.

Stakeholder Participation

The assessment tool was completed with a core group of individuals who committed to participate in a series of meetings over a three-month interval. Members of this group represented a broad spectrum of system partners. Approximately 25 people agreed to participate. Representatives included those from state agencies, advocacy organizations, health systems, local community-based programs, the non-profit sector, institutions of higher education, insurers, and others. Additionally, key individuals with content expertise related to one or more of the EPHS were sought out and encouraged to

participate, as appropriate. All participants were notified of the sections in advance and given the opportunity to prepare their responses prior to the meeting. Appendix B (2004 Assessment Stakeholders List) lists all stakeholders invited and involved in the assessment process

Assessment Tool

The state-level instrument was modified by the Diabetes Council of the Association of State and Territorial Chronic Disease Directors. The modifications involved the inclusion of diabetes language to emphasize the state diabetes public health system. The 98-page 808-item tool included four indicators, consistent with the original instrument, which represented major activities, components, or practice areas of each Essential Service. Model standards, assessment questions, and response options reflected those listed in the original tool.

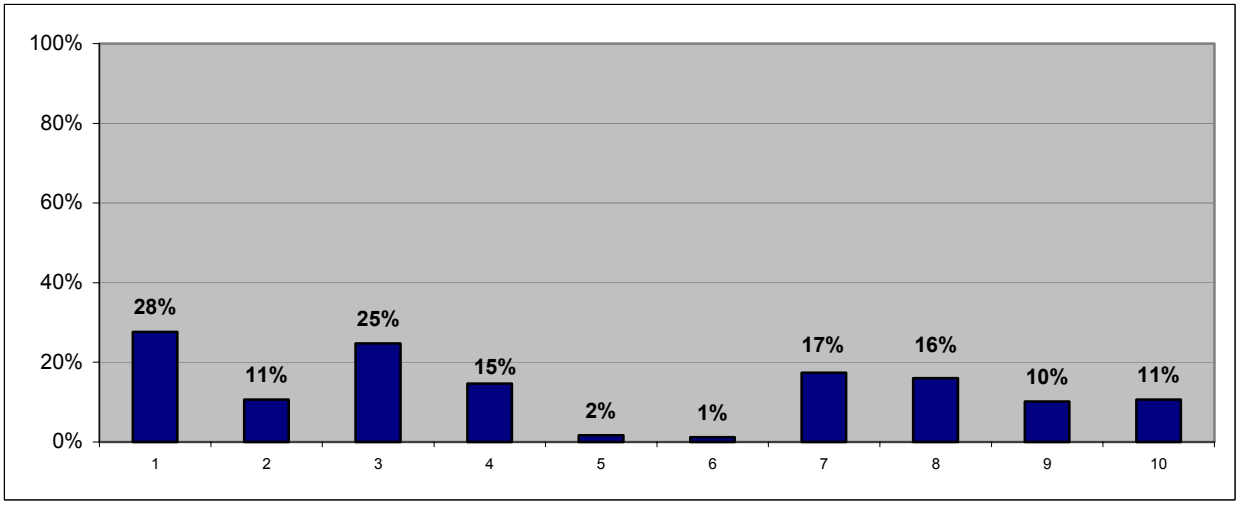
Results

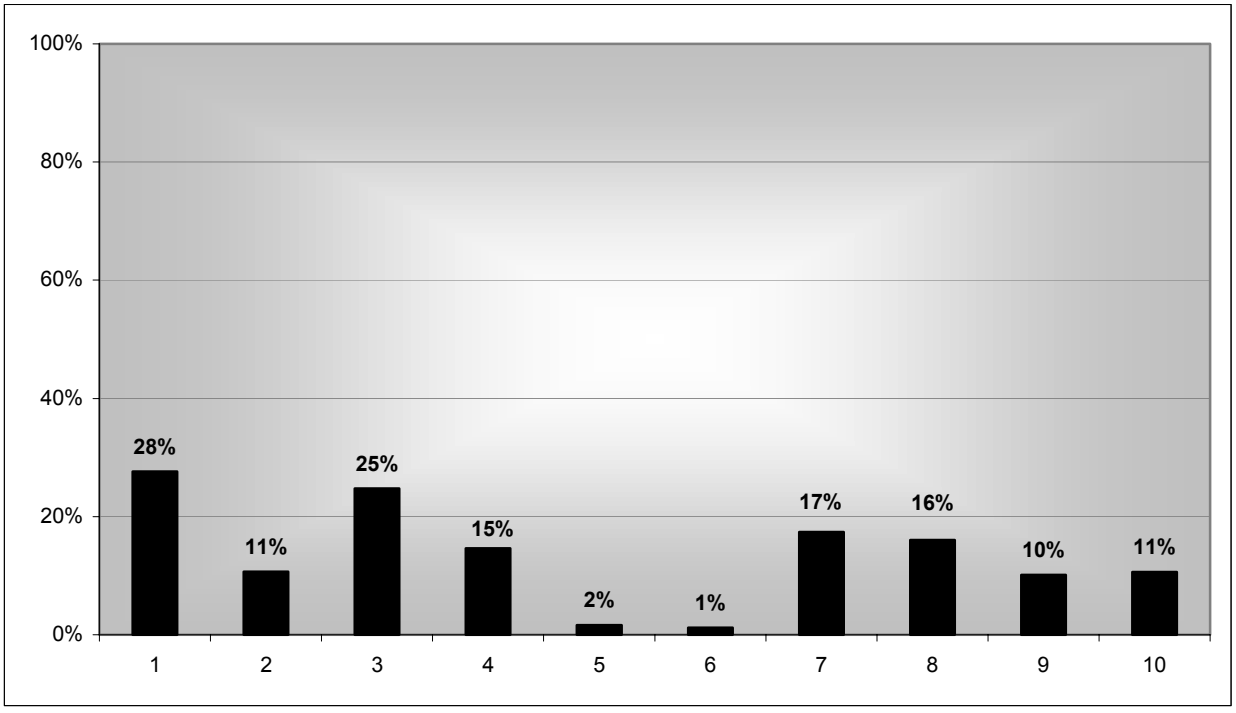
Essential Service Scores:

Each essential service received a score, or percentage, ranging from zero to one hundred. A perfect score of 100% indicates optimal level of performance. Chart 1 depicts the findings. All, the essential services were ranked below 30%, suggesting room for improvement in all areas. The two areas with the most activity are essential services one and three; monitoring health status and educating people about health issues. These findings suggest that essential services five and six have minimal activity when compared to the remaining services. Limited activity may be a reflection of a number of issues, including lack of capacity, resources, time, or low priority, to lack of knowledge by planning participants to name a few. Efforts will be made during the improvement-

planning phase to identify priority areas based on these results and through input from stakeholders who will be participating in our strategic planning process.

Chart 1. Overall Scores for Each Essential Service





Legend:

1. Monitor health status
2. Diagnose and investigate
3. Inform, educate, empower
4. Mobilize community partnerships
5. Develop policies and plans
6. Enforce laws and regulations
7. Link people to needed services
8. Assure a competent workforce
9. Evaluate health services
10. Research for new insights

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Assessment Process and Summary

Many insights and benefits were gained by various systems in the State of Maine about our strengths and weaknesses to provide diabetes related services in a systematic manner. We learned that although various organizations don't view their role as part of a state diabetes health system that with some coordination such a system could be developed. We saw evidence of this in the work of public health programs, academia, and health systems. For example, there are connections between academia and the public health system in collecting and analyzing data. Data results are sometimes shared with health systems to develop improvement programs, but data dissemination does not occur in a coordinated and planned effort. Several partners or stakeholders commented on the value of a process that involved a broad range of stakeholders as a way to share information. Maine's rural nature presents barriers to inter-organizational collaboration resulting in service delivery that is fragmented.

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Performance Improvement and Strategic Planning Process

Results from the SDHS assessment were grouped into five categories to be used by groups of stakeholders in developing a Performance Improvement Plan (PIP) for the DPCP and a strategic plan for the SDHS. The categories and ESPHS areas are listed below:

Category	**ESPHS**
Diabetes Education	3,7,10
Financial/Policy	4,5,6,7,8,10
Surveillance/Data	1,2,9
Care Delivery	7,8
Health Promotion	3,4,7

A decision was made after the completion of the SDHS assessment process to hold strategic planning sessions before conducting a performance improvement plan and implementing change which could run counter to planning developed in a larger stakeholder meeting. The final report on the results of the assessment of the state diabetes health system was delivered by our contractor in March, 2004. A period of three months elapsed before the first strategic planning session in July of 2004. Planning to plan required several meetings between the contractor and the staff of the DPCP before holding the first strategic planning session July 19th. The DPCP program director organized the strategic planning framework (Appendix C: Strategic Planning Outline) to maximize the contributions of stakeholders by organizing workgroups into five categories (shown above). The overall plan is to accomplish the development of a five year strategic plan in draft form and a one year performance improvement plan by end of October, 2004 with a finished product completed by year end. Implementation of the plan will begin in January, 2005.

Approaches to identification and formulation of plans

1. The SDHS assessment process included discussion and ratings from a core group of 25 participants based on their professional experience. Discussion took place in an open facilitated process. Gaps and limitations were detailed in a final assessment report used by the strategic planning teams.
2. Strategic planning sessions involved discussion of gaps and limitations from the SDHS assessment report and used a Strength, Weakness, Opportunities and Threats (SWOT) framework to help drive recommendations for action steps.[1]

A consultant, Pamela McDonald, MPH, researched identified gaps by comparing Maine to other states (when possible), looking at standards, i.e. National Council for Quality Assurance (NCQA), Council of State and Territorial Epidemiologists (CSTE), and searching the literature. A resource of findings was made available to stakeholders in all five topic groups.

Meetings

Two meetings were held totaling 15 hours on July 19th and September 28th. During the first meeting 25 individuals participated and worked in two groups; policy and surveillance meeting for 8 hours. At the second meeting all five groups met with three groups meeting for 7 hours, Education, Care Delivery, and Health Promotion, while Surveillance and Policy met for two hours. Thirty-three individuals attended the second meeting. A third meeting occurred on October 26th to review and approve recommendations and plans. Lists of stakeholders that attended the meetings is Included in Appendix D, E, and F.

[1] The SWOT analyses and recommendations were being transcribed at the time this report was required and may not be available at the time the PIP is submitted.

Essential Public Health Service # 1 Monitor Health Status to Identify Health Problems

SCORES (0-100%):	
Planning and	48%
Technical Assistance	23%
Evaluation and Improvement	16%
Resource Management	23%

Service includes:

- Assessment of health status statewide
- Attention to vital statistics
- Identification of community assets
- Utilization of technology
- Integration of information systems

Gaps:

Surveillance System

- Incidence data are not captured
- Laboratory findings and other local data are not integrated
- Reviews of surveillance system are not currently conducted
- GIS capability is limited, although maps are currently included in report
- No system exists for assisting partners in epidemiologic analysis
- Additional data is needed on barriers to seeking care and disparate groups

Development of Plans

- No plan exists for a coordinated statewide response to diabetes risks that includes laboratories and other collaborators
- No formal plan exists for assessing surveillance activities and setting priorities for improvement

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Communication

- Surveillance efforts and findings are not widely disseminated
- Policy makers are not systematically provided diabetes related information

Resources

- Limited capacity to meet all local needs to identify, analyze, and respond to diabetes risks
- Current law limits ability for opportunistic population screening
- Limited resources for investigation of priority areas for diabetes

Table 1: PIP EPHS #1

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking[2]
1. Develop an ongoing collaboration with partners on data collection. Create a plan to capture data, fill gaps, report findings, disseminate information, and evaluate efforts.	5	3	1	3	1	13	1
2. Integrate existing surveillance efforts to include pre-diabetes and co-morbidity information	5	1	1	5	1	13	2
3. Develop mechanisms to support rigorous data collection efforts statewide on key indicators	5	1	1	3	1	11	3

Plan to Monitor Health Status to Identify Health Problems (EPHS #1)

Table 1 shows three recommendations are achievable through collaboration by statewide partners. Recommendations 1 and 2 are achievable within 5 years. Recommendation number three presents several challenges that will require instituting statewide data collection which may be available once the state completes its development of an all payers database. The DPCP will convene an advisory group, made up of representatives from academia, health systems and payers to identify possible solutions (including an implementation plan) to recommendations 1 and 2 within twelve-twenty-four months. The group will be facilitated by Katie Meyer, PhD, senior epidemiologist at the Bureau of Health. Stakeholders that have made a commitment to assist in addressing surveillance issues from our strategic planning session include representatives from Muskie School of Public Health, Maine General Health Systems, Medicaid, and Maine DP^{2}CP.

[2] The job aid score sheet was used in rating criteria. See Appendix G.

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Essential Public Health Service # 2 Diagnose and Investigate Health Problems

SCORES (0-100%):	
Planning and Implementation	11%
Technical Assistance	18%
Evaluation and Improvement	0%
Resource Management	14%

Service includes:

- Epidemiologic investigation of disease patterns of diabetes and other related conditions
- Opportunistic population-based screening, case finding, investigation and analysis

GAPS:

- Incidence data are not captured
- Laboratory findings and other local data are not integrated
- Reviews of surveillance system are not currently conducted
- GIS capability is limited, although maps are currently included in report
- No system exists for assisting partners in epidemiologic analysis
- Additional data is needed on barriers

Table 2: PIP EPHS #2

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Develop a surveillance evaluation advisory group	5	5	5	5	5	25	1
2. Develop and implement a barriers study of existing DSME structure	5	5	3	5	3	21	2
3. Create a statewide diabetes registry	5	1	1	5	1	13	3
3. Mandate lab results be reported to state	3	1	1	3	1	9	4
5. Hire a GIS professional	3	1	1	1	1	7	5

Plan to Diagnose and Investigate Health Problems (EPHS #2)

Table 2 shows five recommendations to improve performance in diagnosing and investigating health problems (EPHS #2). Recommendations 1 and 3 are achievable within 1 year. The DPCP will take responsibility for organizing a group of stakeholders to work on identifying barriers. Efforts are currently underway to form a focus groups for that purpose. Partners identified to date are Central Maine Medical Center, Southern Maine Visiting Nurses, Quality Improvement Organization, MaineHealth, and Bureau of Medical Services. An initial meeting of the partners to identify focus group compositions that are representative of the state will occur by January 30th, 2005. The remaining recommendations will require longer time frames and fit into our strategic planning of five years.

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Essential Public Health Service # 3 Educate About Health Issues

SCORES (0-100%):	
Planning and Implementation	34%
Technical Assistance	18%
Evaluation and Improvement	30%
Resource Management	17%

Service includes:

- Health education and promotion activities
- Health communication plans and activities
- Accessible health information
- Programs that partner with key groups

GAPS:

Coordination and Collaboration

- Limited coordination and consistency exists across the state for health education programs (e.g. Ambulatory Diabetes Education and Follow-up (ADEF) Program, Healthy Maine Partnerships (HMPs), Department Of Education (DOE)

- Program participants are often not included in the planning and review of programs

Programs

- Health education programs are available statewide, yet gaps exist (i.e. ADEF reaches one-third of patients)
- Few initiatives focus on at-risk or pre-diabetes populations
- National guidelines on effective health education programs are limited, or not widely disseminated
- Many channels for communication are used, yet more could be utilized

Resources/Expertise

- Limited resources are available for evaluating the effectiveness of health education communication efforts
- Maine DPCP has limited expertise in health communication

Table 3: PIP EPHS #3

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Identify Current Barriers to Education and Develop Plan to Address	5	3	3	5	5	21	1
2. Create a Clearing House of Education Opportunity	3	5	3	5	5	21	2
3. Promote "Best Practice" Standards for Diabetes Education	5	1	1	5	3	15	3
4. Collaborate with Partners in Chronic Care to identify and share resources	3	3	3	3	3	15	4

Plan to Educate About Health Issues (EPHS #3)

Table 3 shows four recommendations to inform, educate, and empower about health issues (EPHS #3). Recommendation 3 - Identify Current Barriers to Education and Develop Plan to address - is the same priority recommendation listed in EPHS #2 and is achievable within 1 year. The DPCP will take responsibility for organizing a group of stakeholders to work on identifying barriers. Efforts are currently underway to form a focus group for that purpose. In addition in the first year the DPCP will work with other stakeholders on the Advisory committee to implement Recommendation #2 – Create a Clearing House of Education Opportunity. The remaining recommendations will require longer time frames and fit into our strategic planning of five years. Stakeholders that have made a commitment to assist in addressing education issues from our strategic planning session include:

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Essential Public Health Service # 4: Mobilize Partnerships

SCORES (0-100%):	
Planning and Implementation	21%
Technical Assistance	12%
Evaluation and Improvement	0%
Resource Management	26%

Service Includes:

- Organization and leadership to convene and facilitate statewide partners
- Building of a state-wide partnership
- Assistance to partners and communities to organize

GAPS:

Involvement

- There is limited involvement from some sectors of public health
- Existing partnerships often involve “the same people”

Communication

- No process is in place for routinely engaging and briefing policy leaders and other stakeholders
- There is no mechanism in place to communicate with all diabetes stakeholders on a routine basis, particularly the non-traditional partners
- Many channels for communication are used, yet more could be utilized

Collaboration

- Limited collaboration exists within state government related to diabetes
- Limited evaluation efforts focus on constituency-building, particularly with regard to diabetes
- Benefits and priorities of collaboration at each level are not delineated or fully understood

Table 4: PIP EPHS #4

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. DPCP to develop mechanism for stakeholders to communicate	5	3	3	5	3	19	1
2. Develop new partnerships with non-traditional groups especially in relation to raising public awareness about the risk, burden, and response to diabetes and pre-diabetes	5	3	1	5	3	17	2

Plan to Mobilize Partnerships (EPHS #4)

Table 4 shows recommendations to mobilize partnerships (EPHS #4). The workgroups felt that a strong diabetes community exists but those partnerships outside of the diabetes community are not well connected. The primary goal for the one year plan will be to establish a mechanism for communicating with all diabetes stakeholders, especially the non-traditional partners. The DPCP will be responsible for this goal.

Essential Public Health Service # 5: Develop Policies

SCORES (0-100%):	
Planning and Implementation	0%
Technical Assistance	0%
Evaluation and Improvement	0%
Resource Management	7%

Service Includes:

- Systematic health planning that relies on data
- Support for the development of legislation, policies, guidelines, etc.
- Promotion of a democratic process of dialogue

GAPS:

Planning and Tracking

- A state health plan for diabetes does not exist
- Communities may not have access to local data to set policy priorities
- Progress reports for diabetes health objectives are not available on an annual basis

Table 5: PIP EPHS #5

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. DPCP to fund the development of a diabetes advisory committee	5	3	3	5	3	19	1
2. Develop a position statement within the advisory group on education, healthcare, and support of persons with diabetes	5	3	1	5	3	17	2

Plan to Develop Policies (EPHS #5)

Table 5 shows recommendations to develop policy (EPHS #5). The workgroup made a number of recommendations to develop comprehensive policy, the recommendations that can be acted upon within a year require the formation of a diabetes council representative of stakeholders statewide. This strategy also will incorporate strategy from EPHS # 4 and include non-traditional partners. The advisory group will need to be facilitated and managed by a paid consultatnt in order to assure long term stability. The DPCP will be responsibility for the funding and stakeholders will contrbute through in-kind donations of time and expertise. Outside funding will be sought after one year. Bylaws will be created.

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Essential Public Health Service # 6: Enforce Laws and Regulations

SCORES (0-100%):	
Planning and Implementation	5%
Technical Assistance	0%
Evaluation and Improvement	0%
Resource Management	0%

Service Includes:

- Review, evaluation, and revision of laws and regulations to protect health
- Education of persons and entities obligated to obey or enforce laws and regulations
- Enforcement activities

GAPS:

Planning and Tracking

- Systematic reviews of enforcement practices do not exist
- Specific enforcement guidelines are not documented
- A central place for complaints to be heard and tracked does not exist
- The impact of current laws on the diabetes population are not fully understood

Table 6: PIP EPHS #6

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Advisory committee to review laws and policy of payers related to reimbursement and advocate for payment reform as necessary.	3	3	5	3	3	17	1

Plan to Enforce Laws and Regulations (EPHS #6)

Table 6 shows recommendations to develop policy (EPHS #6). The Policy/Finance workgroup recommended that an advisory group should look at the laws and policy of payers related to reimbursement and advocate for payment reform as necessary.

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Essential Public Health Service # 7: Link People to Needed Services

SCORES (0-100%):	
Planning and Implementation	18%
Technical Assistance	7%
Evaluation and Improvement	28%
Resource Management	17%

SERVICE INCLUDES:

- Assessment of access to and availability of quality services
- Assurances that access is available
- Partnership with public, private, and voluntary sectors
- Development of improvement process

GAPS:

Coordination and Data

- Assessment activities are not coordinated statewide
- Information currently collected may not be specific to diabetes
- Limited data is available at the local level and for underserved populations, specifically those with diabetes and those at risk of diabetes

Programs/Services

- Systematic statewide reviews of programs using national guidelines are not done
- Access programs are often not specific to diabetes and only available in select locations
- Barriers to accessing care and gaps in the availability of services may not be well understood
- Mental health is becoming an increasing need among program recipients

Resources

- Limited staff time and expertise available to evaluate and track diabetes related health care availability, access, usage, and quality of care
- Few people in Maine currently conduct rigorous health care analysis specific to diabetes
- Significant resources have been invested in chronic disease in Maine, yet few of the efforts or resources specifically focus on diabetes
- Dirigo Health

Table 7: PIP EPHS #7

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Identify Current Barriers to Education and Develop Plan to Address	5	3	3	5	5	21	1
2. Create a Clearing House of Education Opportunity	3	5	3	5	5	21	2
3. Promote "Best Practice" Standards for Diabetes Education	5	1	1	5	3	15	3
4. Collaborate with Partners in Chronic Care to identify and share resources	3	3	3	3	3	15	4

Plan to Link People to Needed Services (EPHS #7)

Table 7 shows four recommendations to Link People with Essential Health services (EPHS #7). Recommendation 3 - Identify Current Barriers to Education and Develop Plan to address - is the same priority recommendation listed in EPHS #2 & EPHS # 3 and is achievable within 1 year. The DPCP will take responsibility for organizing a group of stakeholders to work on identifying barriers. Several stakeholders from the diabetes education community stepped forward to contribute time and expertise. Efforts are currently underway to form a focus group for that purpose. In addition in the first year the DPCP will work with other stakeholders on the Advisory committee to implement Recommendation #2 – Create a Clearing House of Education Opportunity. The remaining recommendations will require longer time frames and fit into our strategic planning of five years. Partners agreeing to be involved in this plan are: the QIO, University of New England, Central Maine Medical Center, Chronic Disease Medical Director, and the Southern Maine Visiting Nurses.

Essential Public Health Service # 8: Assure a Competent Workforce

SCORES (0-100%):	
Planning and Implementation	20%
Technical Assistance	0%
Evaluation and Improvement	16%
Resource Management	28%

SERVICE INCLUDES:

- Education, training, and assessment of health professionals
- Efficient process for credentialling
- Adoption of im-provement programs
- Partnerships with workforce programs
- Continuing education

GAPS:

Development of Plans

- Maine lacks a workforce development plan that coordinates lifelong learning opportunities and strategies to develop competencies
- Maine does not have a process for assessing the diabetes-related workforce
- The chronic care model should be integrated into medical education

Trainings

- Limited opportunities exist to publicize educational opportunities on websites that are routinely maintained
- Training is limited for non-degree individuals (e.g. certified nurse and medical assistants)
- Personnel are often forced to participate in educational programs on their own time
- Lifelong learning may be supported, but few employer incentives exist
- Local data related to professionals (nurses specializing in diabetes, dietitians and others where practice focuses on diabetes), if available, is often limited

Resources

- Limited resources are available for workforce development
- Many public health professionals are recruited from out-of-state
- The system is reactive and no current payment streams exist to support workforce development activities

Table 8: PIP EPHS #8

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Assess the capacity in the statewide diabetes workforce	5	3	3	5	3	19	1

Plan to Assure a Competent Workforce (EPHS #8)

Table 8 shows one recommendation for assuring a competent workforce (EPHS #8), our plan involves the Area Health Education Consortium (AHEC, University of New England and Maine Center for Public Health) including the diabetes workforce in its statewide analysis of the health system workforce. A representative from the AHEC, the Maine Center for Public Health committed to this goal beginning in January, to be completed by December 2005.

Essential Public Health Service # 9: Evaluate Health Services

SCORES (0-100%):	
Planning and Implementation	8%
Technical Assistance	0%
Evaluation and Improvement	22%
Resource Management	10%

Service includes:

- Evaluation and critical review of health programs for decision-making and resource allocation
- Assessment of and quality improvement in systemwide performance and capacity

GAPS:

Evaluation Efforts

- No systematic statewide evaluation exists specific to diabetes or pre-diabetes
- Evaluation efforts and findings are rarely shared among all stakeholders
- Current data gaps pose challenges for evaluation

Technical Assistance

- Technical assistance in the area of evaluation is not specific to diabetes
- Limited technical assistance opportunities exist on an ongoing basis

Resources

- Limited resources exist to make improvements based on evaluation findings
- Limited capacity exists to review evaluation and quality improvement activities on a predetermined, periodic basis

Table 9: PIP EPHS #9

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
4. Develop a surveillance evaluation advisory group	5	5	5	5	5	25	1

Plan to Evaluate Health Services (EPHS #9)

Table 9 shows one recommendation for improving the evaluation of health services (EPHS #9) in one year. The recommendation is to form an advisory group of professionals to review systems, health data collection and analysis, protocols, and strategies that pertain to the diabetes health system. Partners that committed to this activity include a senior epidemiologist from the University of Southern Maine, Health Policy Professor and researcher, Maine General program manager, data analyst from the University of Maine, and DPCP staff. The group will convene by January 30th, 2005 and begin to inventory the issues in detail that have been generally identified in the strategic plan. Recommendations for action steps will be made available to the Diabetes Advisory council by 12/31/05.

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Essential Public Health Service # 10: Research for New Insight

SCORES (0-100%):	
Planning and Implementation	3%
Technical Assistance	0%
Evaluation and Improvement	5%
Resource Management	35%

Service Includes:

- Full continuum of research
- Linkage with research institutions and other institutes of higher learning
- Internal capacity to mount timely epidemiologic and economic analyses

GAPS:

Research Activities

- Maine does not have a research agenda specific to diabetes
- Research dissemination activities are inconsistent and vary considerably
- Existing research efforts are not initiated by the diabetes system
- Translating research to local initiatives and settings can be challenging

Technical Assistance

- Technical assistance in the area of research is limited, particularly for interpreting results and generalizing the findings
- Limited technical assistance exists with regard to applying research findings to population-based interventions

Resources

- Limited workforce resources exist to conduct rigorous research in the area of diabetes
- Maine's skilled researchers are often not available

Table 10: PIP EPHS #10

Recommendations	Importance	Cost	Time	Commitment	Feasibility	Total Points	Priority Ranking
1. Develop a plan to monitor and develop research capacity in the state specific to diabetes	3	3	3	3	3	15	1

Plan to Research for New Insight (EPHS #10)

Table 10 shows one recommendation for investigating increasing research activity specific to diabetes in Maine (EPHS #10) in one year. The recommendation is to develop a plan to monitor and develop research capacity in the state specific to diabetes. The surveillance committee (already identified in EPHS #9) will be responsible for this. The first year goal is to catalog all research and project efforts and to develop a system for ongoing monitoring. Capacity building can be recommended to the AHEC and other interested entities once data is collected and summarized. The activity is planned for one year to coincide with activity in EPHS #9.

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Diabetes Education Workgroup: The following members of the workgroup have committed to the DPCP their time and expertise to work on essential public health services 3 and 7 to address statewide gaps and limitations in the creation of a performance improvement plan and a long range strategic plan.

Julie Barnes, RD, CDE	ME Center for Diabetes	Diabetes Educator
Claudette Bean, RN	Medical Care Development	Health Program Manager
Laura Gordon, RN, CDE	Home Health Visiting Nurses	Home health nurse
Dana Green, PA	St. Joseph's Health Center	Clinician
DeEtte Hall, RN	ME Dept. of Education	Nurse Consultant
Tina Love, RN, CDE	Central ME Medical Center	Diabetes Educator
Doreen McDonald	Bureau of Elder and Adult Svcs	Program Manager
Susan McKenney, RN	Anthem BC/BS	Health Communications
Christine Sady, RD	Maine Nutrition Network	Program Director
Laura Vittorioso, CRT	Iris Network	Program Manager
Alison Webb	Webb Management Svcs.	Consultant
Lucinda Hale, RD, CDE	DPCP	Education Specialist

Financial and Policy Workshop: The following members of the workgroup have committed to the DPCP their time and expertise to work on essential public health services 4, 5, 6, 7 , 8 and 10 to address statewide gaps and limitations in the creation of a performance improvement plan and a long range strategic plan.

John Branscombe, MSB	Maine Network for Health	Program Director
Ann Conway, PhD	Maine Center for Public Health	Project Coordinator
Lori Kaley, MS, RD	Muskie School	Program Director
Kevin Lewis	Maine Primary Care Association	Program Director
Pamela MacDonald	Maine Center for Public Health	Consultant
Leslie Molleur, MPH BSN, RN	Northeast Health Care Quality Foundation	Quality Improvement Specialist
Deborah Silberstein, RN	Anthem BlueCross/BlueShield	Quality Improvement
Debra Wigand	ME Cardiovascular Health Program	Program Director

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Surveillance and Data Workgroup: The following members of the workgroup have committed to the DPCP their time and expertise to work on essential public health services 1, 2, and 9 to address statewide gaps and limitations in the creation of a performance improvement plan and a long range strategic plan.

David Hartley, PhD	Muskie School of Public Service	Researcher, Public Health
Prashant Mittal, MS	Muskie School of Public Service	Data analyst
Deborah Thayer, MBA	Muskie School of Public Service	Data analyst
Natalie Morse	Maine General Health Systems	P.I. RWJ Diabetes Project
Jean Lloyd, RN	Medicaid	QI Specialist
Jim Leonard, MSW	DPCP	Data Analysis, Project Dir.
Dan Mingle, MD, MS	Maine General Health Systems	EMR Developer
Katie Meyer, PhD	Muskie School/USM	Epidemiologist

Maine Diabetes Prevention and Control Program

2005 Performance Improvement Plan

Care Delivery: The following members of the workgroup have committed to the DPCP their time and expertise to work on essential public health services 7 and 8 to address statewide gaps and limitations in the creation of a performance improvement plan and a long range strategic plan.

Linda Gray, RN, BSN	ME Primary Care Association	Program Coordinator
Lisa Letourneau, MD	Maine Health	Program Director
Daniel Mingle, MD	MaineGeneral Health	EMR Developer
Molly Schwenn, MD	ME Cancer Registry & Chronic Disease	Program Director
Dennis Shubert, MD	Dirigo Health Office	Program Director
Merle Taylor, MPH, RN	Northeast Health Care Quality Foundation	Quality Improvement Specialist
Meredith Tipton, PHD, MPH	University of New England	Program MPH

Maine Diabetes Prevention and Control Program

2005 Performance Improvement Plan

Health Promotion: The following members of the workgroup have committed to the DPCP their time and expertise to work on essential public health services 2, 4 and 7 to address statewide gaps and limitations in the creation of a performance improvement plan and a long range strategic plan.

Joanne Bean, BSN, MBA	American Diabetes Assoc.	Regional Director
Andrew Finch, MSW	BOH, Healthy Maine Partnership	Program Director
Nellie Hedstrom, RD	University of Maine Cooperative Extension	Nutrition Specialist
Karen O'Rourke, MPH	Maine Center for Public Health	Vice President

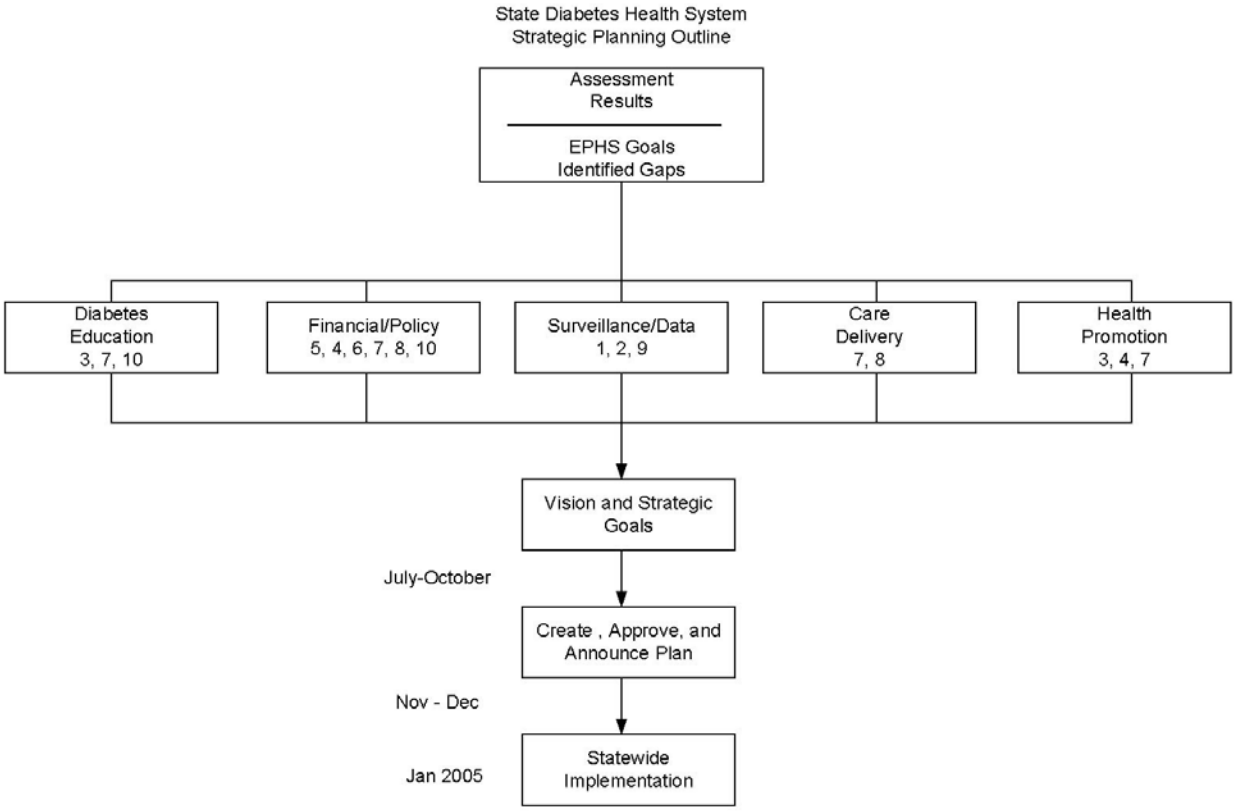
Appendix A: EPHS and Indicators

EPHS and Indicator	Model Standard			
	Fully Met	Mostly Met	Partially Met	Not Met
	>75	51-75	25-50	<25
1. Monitor Health Status				
1. Measure, analyze, report diabetes health status of state			X	
2. Provide assistance, capacity-building, and resources to partners				X
3. Review monitoring activities for quality improvement				X
4. Effectively invest, manage, utilize monitoring resources				X
2. Diagnose/Investigate Health Problems				
1. Work collaboratively with partners to respond to health threats				X
2. Provide epidemiological assistance and information about health threats				X
3. Review surveillance system and response plans				X
4. Effectively invest, manage, utilize surveillance resources				X
3. Inform about Health Issues				
1. Plan and implement health communication/education initiatives			X	
2. Provide assistance, capacity-building, and resources to partners				X
3. Review health communication/education/promotion activities			X	
4. Effectively invest, manage, utilize health education resources				X
4. Mobilize Community Partnerships				
1. Engage community, constituents, and develop partnerships				X
2. Provide training and TA on constituency/partnership development				X
3. Review activities related to partnership mobilization				X
4. Effectively invest, manage, utilize partnership mobilization resources			X	
5. Develop Policies and Plans that Support Health Efforts				
1. Implement health improvement plan/policy development				X
2. Provide training and TA on policy development				X
3. Review activities related to partnership mobilization				X
4. Effectively invest, manage, utilize planning and policy resources				X
6. Enforce Laws and Regulations that Protect Health				
1. Review regulations, educate, administer enforcement activities				X
2. Provide training and TA on enforcement, protocols, compliance				X
3. Review activities related to enforcement				X
4. Effectively invest, manage, utilize enforcement resources				X
7. Link People to Needed Services and Assure Provision of Care				
1. Assess availability and assure access, utilization, and quality				X
2. Provide assistance to meet needs of medically underserved				X
3. Review activities related to assuring access, utilization, and quality			X	
4. Effectively invest, manage, utilize resources to assure provision of care				X
8. Assure Competent Public and Personal Health Care Workforce				
1. Identify workforce needs, implement recruitment/retention policies				X
2. Provide assistance to partners to assure competent workforce				X
3. Review activities related to workforce needs, achievements				X
4. Effectively invest, manage, utilize workforce resources			X	
9. Evaluate Personal and Population-Based Health Services				
1. Plan and implement evaluation processes				X
2. Provide assistance to meet evaluation needs of partners				X
3. Review activities related to evaluation				X
4. Effectively invest, manage, utilize evaluation resources				X
10. Research for Innovative Solutions to Health Problems				
1. Participate in research activities and contribute to science-base				X
2. Provide assistance in participating in and interpreting research				X
3. Review research activities				X
4. Effectively invest, manage, utilize research resources			X	

Appendix B: 2004 Assessment Stakeholder List

NAME	ORGANIZATION
Amundsen, Susan	Martin's Point Healthcare-ADEF
Bean, Joanne	American Diabetes Association
Bell, Karen	Anthem BCBS
Burns, Jesse	Downeast Community Hospital-ADEF
Caine, Pam	Mount Desert Island Hospital-ADEF
Carter, Simone	Houlton Band of Maliseet Indians
Corkum, Brenda	Office of Data Research and Vital Stats
Courtois, Jennifer	Southern Maine Health & Homecare-ADEF
Davis, Marla	Mid Coast Hospital
DiDominicus, Deborah	So. Me. Agency on Aging
Dutch, Jeff	Maine Optometric Association
Foster, Pamela	Bureau of Health
Freshly, Carol	Mid Coast Hospital
Gordon, Laura	Community Health Services (fax 877-239-4559)
Graber, Judith	Behavioral Risk Factor Surveillance System
Halbach, Deborah	Maine Academy of Family Physicians
Hale, Lucinda	Maine DPCP
Hall, DeEtte	Dept. of Education
Hartley, David	USM, Muskie School
Joly, Brenda	Maine Center for Public Health
Lemieux, Don	Office of Data Research and Vital Stats
Leonard, Barbara	Division of Community Health
Leonard, Jim	Bureau of Health
Letourneau, Lisa	MaineHealth
Lewis, Jini	Maine Primary Care Association
Lewis, Kevin	Maine Primary Care Association
Lloyd, Jean	Bureau of Medical Services
Love, Tina	Central Maine Medical Center-ADEF
Lyman, Christine	Community Health Program
McClain, Monica	Foundation for Blood Research
McDaniel, Doreen	Bureau of Elder and Adult Services
Meyer, Katie	Chronic Disease Epidemiologist
Morris, Nancy	Maine Health Alliance
Morse, Natalie	MaineGeneral Health
Nurse, Pat	MaineGeneral Medical Center-ADEF
O'Rourke, Karen	Maine Center for Public Health
Pelletreau, Katherine	Maine Association of Health Plans
Penney, Alexandra	Portland Community Free Clinic
Perry, Bill	Maine Health Information Center
Pritham, Robin	EMMC Residency Program
Putz, Gene	Nordx Labs
Ricker, Valerie	Division of Family Health
Rines, Emily	Coastal Healthy Communities Coalition
Robinson, Pat	Healthy Maine Partnerships
Ronan, Laura	Me Clinical Consortium for Office System Improvement
Roy, Joyce	Public Health Nursing
Roy, Randel	Eastern Maine Medical Center
Sady, Chris	Maine Nutrition Network
Sauda, Valerie	Elder Independence of Maine
Scott, Muriel	Senior Spectrum
Silberstein, Deborah	Anthem Blue Cross and Blue Shield
Spofford, Kay	Sebasticook Valley Hospital-ADEF
Stone, Bonnie	Mayo regional Hospital-ADEF
Tipton, Meredith	UNE, College of Osteopathic Medicine
Vittorioso, Laura	The Iris Network
Wall, Toni	Children with Special Health Needs
Walsh, Donna	Inland Hospital-ADEF
Watson, Pat	Stephens Memorial Hospital-ADEF
Wexler, Richard	Medical Care Development
Whitley, Dennise	American Heart Association
Wigand, Debra	Maine CV Health Program
Yindra, John	Central and Western Maine PHO
Young, Susan	Blue Hill Memorial Hospital-ADEF
Zaremba, Maryann	Maine DPCP

Appendix C: Strategic Planning Outline



Appendix D: Strategic Planning Stakeholder List Meeting 1

Attendees for July 19, 2004 Meeting		
First Name	**Last Name**	**Agency**
Joanne	Bean	American Diabetes Association
John	Branscombe	Maine Network for Health
Carol	Cherry	Medicare Medical Review & Appeals
Ann	Conway	Maine Center for Public Health
Andrew	Finch	BOH, Healthy Maine Partnership
Linda	Gray	Maine Primary Care Association
David	Hartley	Muskie School of Public Service
Lori	Kaley	Muskie School
Jim	Leonard	Diabetes Prevention & Control Program
Lisa	Letourneau	MaineHealth
Kevin	Lewis	Maine Primary Care Association
Jean	Lloyd	Bureau of Medical Services
Pamela	MacDonald	Consultant
Katie	Meyer	BOH, Chronic Disease Epidemiology
Katie	Michaud	MaineGeneral Specialty Practice
Daniel	Mingle	MaineGeneral Health
Prashant	Mittal	Muskie School of Public Service
Leslie	Molleur	Northeast Health Care Quality Foundation
Natalie	Morse	MaineGeneral Health
Karen	O'Rourke	Maine Center for Public Health
Deborah	Silberstein	Anthem Blue Cross Blue Shield
Suanne	Singer	Maine Health Information Center
Deborah	Thayer	Muskie School of Public Service
Meredith	Tipton	University of New England
Alison	Webb	Webb Management Services

Appendix E: Strategic Planning Stakeholder List Meeting 2

Attendees at September 28, 2004 Meeting

First Name	Last Name	Agency
Julie	Barnes	The Maine Center for Diabetes
Claudette	Bean	Medical Care Development
Joanne	Bean	American Diabetes Association
Ann	Conway	Maine Center for Public Health
Jennifer	Courtois	So. Maine Medical Ctr Visiting Nurses
Andrew	Finch	BOH, Healthy Maine Partnership
Carol	Freshley	Community Health & Nursing Services
Linda	Gray	Maine Primary Care Association
Dana	Green	St. Joseph Healthcare
Lucinda	Hale	Bureau of Health/DPCP
DeEtte	Hall	Department of Education
David	Hartley	Muskie School
Nellie	Hedstrom	University of Maine Cooperative Extension
Lori	Kaley	Muskie School
Jim	Leonard	BOH/Diabetes Prevention & Control ProGRAM
Tina	Love	Central Maine Medical Center
Doreen	McDaniel	Bureau of Elder and Adult Services
Pamela	MacDonald	Consultant
Susan	McKenney	Anthem Blue Cross Blue Shield
Katie	Meyer	BOH, Chronic Disease Epidemiology
Daniel	Mingle	MaineGeneral Health
Leslie	Molleur	Northeast Health Care Quality Foundation
Natalie	Morse	MaineGeneral Health
Karen	O'Rourke	Maine Center for Public Health
Chris	Sady	Maine Nutrition Network
Molly	Schwenn	BOH/Maine Cancer Registry
Dennis	Shubert	Dirigo Health Office
Merle	Taylor	Northeast Health Care Quality Foundation
Deborah	Thayer	Muskie School of Public Service
Meredith	Tipton	University of New England
Laura	Vittorioso	The Iris Network
Alison	Webb	Webb Management Services
Debra	Wigand	Maine Cardiovascular Health Program

Appendix F: Strategic Planning Stakeholder List Meeting 3

Attendees at October 26, 2004 Meeting

First Name	Last Name	Agency
Julie	Barnes	The Maine Center for Diabetes
Claudette	Bean	Medical Care Development
John	Branscombe	Maine Network for Health
Ann	Conway	Maine Center for Public Health
Jennifer	Courtois	Southern Maine Medical Center Visiting Nurses
Marla	Davis	Mid Coast Hospital
Carol	Freshley	Mid Coast Hospital
Dana	Green	St. Joseph Healthcare
Lucinda	Hale	Diabetes Prevention and Control Program
DeEtte	Hall	Department of Education
Lori	Kaley	Muskie School
John	LaCasse	Medical Care Development
Jim	Leonard	Diabetes Prevention & Control Program
Jean	Lloyd	Bureau of Medical Services
Madeline	Martin	Penobscot Nation Health Department
Doreen	McDaniel	Bureau of Elder and Adult Services
Katie	Meyer	BOH, Chronic Disease Epidemiology
Natalie	Morse	MaineGeneral Health
Karen	O'Rourke	Maine Center for Public Health
Chris	Sady	Maine Nutrition Network
Molly	Schwenn	Maine Cancer Registry & Chronic Disease
Deborah	Silberstein	Anthem Blue Cross Blue Shield
Merle	Taylor	Northeast Health Care Quality Foundation
Deborah	Thayer	Muskie School of Public Service
Meredith	Tipton	University of New England

Appendix G: Job Aid: Recommendation Assessment Worksheet: Rating Criteria[3]

Importance	**How important is the recommendation?** **5 = Very important** **3 = somewhat important** **1 = Not very important**
Cost	**How expensive would it be to plan and implement the recommendation?** **5 = Not very expensive** **3 = Moderately expensive** **1 = Very expensive**
Time	**How much time and effort would be needed to implement the recommendation?** **5 = Modest time and effort** **3 = Somewhat high time and effort** **1 = Very high time and effort**
Commitment	**How enthusiastic would the diabetes system be about implementing the recommendation?** **5 = Very enthusiastic** **3 = Somewhat enthusiastic** **1 = Not enthusiastic**
Feasibility	**How attainable is the recommendation?** **5 = Fairly easy to attain** **3 = somewhat difficult to attain** **1 = Very difficult to attain**

[3] Job Aid Score Sheet. Division of Diabetes Translation's (DDT) PIP Tool Kit